

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **16679**

No. 300  
10-48

**FILED APR 29 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1032**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>St. Louis, Co.</b>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY _____ |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Manchester</b>  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>  |  |
| c. LENGTH OF STAY (in this place) <b>10 1/2 yrs</b>   |  | d. STREET ADDRESS (If rural, give location) <b>3865 Kennerly</b>   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>PINE CREST NURSING HOME</b> |  |  |  |

|   |  |  |  |  |
|---|--|--|--|--|
| <b>3. NAME OF DECEASED</b><br>(Type or Print) a. (First) <b>ANNA</b> b. (Middle) _____ c. (Last) <b>SUEVERS</b> |  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 9 1953</b> |  |
|---|--|--|--|--|

|                             |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|-----------------------------|--|--------------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| <b>5. SEX</b> <b>female</b> |  | <b>6. COLOR OR RACE</b> <b>white</b> |  | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>widowed</b> |  | <b>8. DATE OF BIRTH</b> <b>April 25 1885</b> |  | <b>9. AGE</b> (In years last birthday) <b>78</b> |  | <b>IF UNDER 1 YEAR</b> Months _____ Days _____ |  | <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____ |  |
|-----------------------------|--|--------------------------------------|--|--|--|--|--|--|--|--|--|--|--|

|   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b> |  |  | <b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>East St. Louis Ill.</b> |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b> |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|

|  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| <b>13a. FATHER'S NAME</b> <b>William W. Gibson</b> |  |  | <b>13b. MOTHER'S MAIDEN NAME</b> <b>Katherine Shea</b> |  |  | <b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b> |  |  |
|--|--|--|--|--|--|--|--|--|

|   |  |  |  |  |  |  |  |                                     |  |
|---|--|--|--|--|--|--|--|-------------------------------------|--|
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <b>No</b> |  | <b>16. SOCIAL SECURITY NO.</b> <b>None</b> |  | <b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Theodore Suevers</b> |  |  |  | <b>ADDRESS</b> <b>3865 Kennerly</b> |  |
|---|--|--|--|--|--|--|--|-------------------------------------|--|

|  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | <b>MEDICAL CERTIFICATION</b>  |  |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> |  |
|  |  | <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Acute Cardiac Dilatation</b>           |  |  |  |  |  |   |  |
|  |  | <b>ANTECEDENT CAUSES</b>  |  | <b>DUE TO (b)</b> <b>Chronic Myocarditis</b>   |  |  |  |   |  |
|  |  | <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> |  | <b>DUE TO (c)</b> <b>Hemoplegia</b>  |  |  |  |   |  |
|  |  | <b>II. OTHER SIGNIFICANT CONDITIONS</b>   |  | <b>Conditions contributing to the death but not related to the disease or condition causing death.</b> |  |  |  |   |  |

|                               |  |   |  |  |  |  |  |  |  |
|-------------------------------|--|---|--|--|--|--|--|--|--|
| <b>19a. DATE OF OPERATION</b> |  | <b>19b. MAJOR FINDINGS OF OPERATION</b> |  |  |  |  |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|-------------------------------|--|---|--|--|--|--|--|--|--|

|  |  |   |  |   |  |                                   |  |                      |  |
|--|--|---|--|---|--|-----------------------------------|--|----------------------|--|
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)              |  | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | <b>21c. (CITY, TOWN, OR TOWNSHIP)</b> _____   |  | <b>(COUNTY)</b> _____             |  | <b>(STATE)</b> _____ |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ |  |   |  | <b>21e. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b> |  |                      |  |

**22. I hereby certify that I attended the deceased from Jan. 1951, to Apr. 8, 1953, that I last saw the deceased alive on Apr. 19, 1953, and that death occurred at 11 P. M., from the causes and on the date stated above.**

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| <b>23a. SIGNATURE</b> (Degree or title) <b>C. H. Leslie M.D.</b> |  |  | <b>23b. ADDRESS</b> <b>209 So. Kirkwood</b> |  |  | <b>23c. DATE SIGNED</b> <b>4/10/53</b> |  |  |
|--|--|--|---|--|--|--|--|--|

|   |  |                                 |  |   |  |  |  |  |  |
|---|--|---------------------------------|--|---|--|--|--|--|--|
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b> |  | <b>24b. DATE</b> <b>4/13/53</b> |  | <b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Valhalla Crematory</b> |  | <b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County</b> |  |  |  |
|---|--|---------------------------------|--|---|--|--|--|--|--|

|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| <b>DATE REC'D BY LOCAL REG.</b> <b>4-10-53</b> |  | <b>REGISTRAR'S SIGNATURE</b> <b>Hubert R. Drake M.D.</b> |  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Sullivan's</b> |  |  |  |  | <b>ADDRESS</b> <b>2849 N. Euclid Ave.</b> |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|

\* (Licensed Embalmer's Statement on Reverse Side)

APR 20 1944

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Robert L. Brunkma

Licensed Embalmer No. 3553

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.